Qualitative study of decisions about infant feeding among women in east end of London

Pat Hoddinott, Roisin Pill

Macduff Medical Practice, Macduff, Banffshire AB44 1PR
Pat Hoddinott, *general practitioner*

Department of General Practice, University of Wales College of Medicine, Llanedeyrn Health Centre, Maelfa, Cardiff CF3 7PN
Roisin Pill, *professor of general practice research*

Correspondence to: Dr Hoddinott hoddinott@dial.pipex.com

BMJ 1999;318:30–4

Abstract

Objective To improve understanding of how first time mothers who belong to a socioeconomic group with particularly low rates of breast feeding decide whether or not to initiate breast feeding.
Design Qualitative semistructured interviews early in pregnancy and 6-10 weeks after birth.
Setting Women's homes in east end of London.
Subjects 21 white, low income women expecting their first baby were interviewed mostly at home, often with their partner or a relative. Two focus groups were conducted.
Results Women who had regularly seen a relative or friend successfully breast feed and described this experience positively were more confident about and committed to breast feeding. They were also more likely to succeed. Exposure to breast feeding, however, could be either a positive or a negative influence on the decision to breast feed, depending on the context. Women who had seen breast feeding only by a stranger often described this as a negative influence, particularly if other people were present. All women knew that breast feeding has health benefits. Ownership of this knowledge, however, varied according to the woman's experience of seeing breast feeding.
Conclusions The decision to initiate breast feeding is influenced more by embodied knowledge gained from seeing breast feeding than by theoretical knowledge about its benefits. Breast feeding involves performing a practical skill, often with others present. The knowledge, confidence, and commitment necessary to breast feed may be more effectively gained through antenatal apprenticeship to a breastfeeding mother than from advice given in consultations or from books.

Introduction

Increasingly medical research is showing the health benefits of breast feeding for both mothers and babies.[1–3] The number of women who start breast feeding in Britain, however, has changed little since 1980,[4 5] despite many health promotion initiatives.[6–8]

Previous research into decision making about infant feeding has predominantly used surveys to look at the sociodemographic variables and attitudes associated with breast feeding,[4 9–12] and negative associations have been found consistently with young mothers, low social class, and stopping full time education at an early age.

The underlying assumption of these studies is a rational model of decision making whereby women weigh up the pros and the cons of breast feeding and decide accordingly. There is little robust evidence, however, that education increases rates of breast feeding, and most women who choose formula feeding "know" that breast feeding would be better for their babies.[9] The limitations of a health promotion model and the need for more sociocultural models for understanding how women make decisions about infant feeding is discussed by Maclean in her overview of the literature.[13] She highlights the lack of qualitative research in a topic where surveys predominate.

This qualitative research arose from involvement of one of the authors (PH) in commissioning maternity services, where attempts were being made to increase local rates of breast feeding. We set out to explore how first time mothers from an inner city area decide whether to breast or bottle feed by focusing on their knowledge and previous exposure to infant feeding and its relation to their decision.

Subjects and methods

Twenty one white women of lower social class and with low educational level who were having their first baby and were living in a deprived inner London health authority were selected for investigation as they belong to a group known to have low rates of breast feeding. They were initially approached about the study before antenatal booking by general practitioners and midwives known to the researcher (PH). The aim was to interview the women as soon as possible after confirmation of pregnancy to ascertain their views before professional input about infant feeding. If they agreed they were contacted by PH who introduced herself as a researcher, not a doctor, and explained that the research was about choices women make when they are looking after their first baby. This enabled infant feeding to be discussed in the wider context of pregnancy and family life according to the woman's own priorities. The infant feeding agenda was declared later in the interview. Ethics committee approval was obtained.

Recruitment

Contrary to expectations women initially recruited were older and intended to breast feed, so purposeful sampling[14] was used to target teenage women who intended to formula feed to ensure that all viewpoints were represented. Eight women recruited knew that PH was a doctor but were not her patients. A discussion of the influence of her role as a researcher and a general practitioner on both the recruitment and the interview data has been reported elsewhere.[15] Recruitment ceased when theoretical saturation had been reached.[16] Twenty one women were interviewed antenatally, of whom 19 were reinterviewed 6-10 weeks after the birth. Two women had moved away.

Interviewing

Data were collected with a topic guide developed during four pilot interviews rather than with a structured questionnaire to enable respondents to tell their stories in their own way. Women chose the time and place of interview (all except three took place at home) and whether to be interviewed alone or with another person of their choice (nine partners, three mothers, one father, and two sisters). Interviews were tape recorded, fully transcribed, and field notes of reflexive observations were recorded in a research diary.

Two focus groups were also conducted by PH to gain insight into the social context in which decisions about infant feeding are made. The five participants in each focus group were identified as important sources of support by women in the study. They were female friends or relatives with whom they (the subjects) spent a great deal of time and treated as confidants. Each focus group was tape recorded and transcribed by PH.

Data collection and analysis

Data collection and analysis proceeded in an iterative manner in accordance with grounded theory,[17] allowing concepts to be confirmed, rejected, or modified as the study progressed. The framework method of data analysis[18] was applied systematically both within and across cases with categories and themes identified by reading the transcripts. A coding index was developed and applied to each transcript with Microsoft Word computer software. The language used by women when they discussed their intentions about infant feeding was examined in detail using the principles of discourse analysis.[19]

Validation and trustworthiness

Respondent validation was used to check whether the data analysis and interpretation truly represented the women's views. The 19 women remaining in the study were sent a synopsis of their individual case analysis, together with a summary of the key research findings. Confirmatory feedback was received from 11 women, with two letters being returned undelivered. The emerging analysis was cross checked with data obtained from different sources (individuals, couples, and the focus group interviews). Both authors were involved in reading and analysing transcripts. This paper focuses on the views expressed by the index women unless otherwise stated. A more detailed account of the research methodology and findings is available.[20]

Table 1 Sample characteristics of 21 women interviewed about breast feeding

Characteristic	No of women
Age (years):	
16-20	6
21-30	10
31-40	5
Housing:	
Owner occupied	6
Rented	15
Living arrangements:	
Living separately from the father of baby:	
Living alone	2
Living with one other person	2
Living with two or more people	4
Living with father of baby:	
Living as couple	11
Sharing with others	2
Mother's age at completing full time education (years):	
⩽16	18
17 or 18	2
>18	1
Mother's employment status at time of antenatal interview:	
Full time employment	9
Half time or temporary employment	4
Unemployed	6
Student	2
Method of delivery:	
Spontaneous vaginal delivery	12
Assisted delivery	7
Elective caesarean under general anaesthetic	1
Moved out of area; no birth details available	1
Complications in baby:	
35 Week gestation; admitted to special care for 7 days	1
Meconium aspiration at term; in neonatal unit for 24 hours	1
Ventricular septal defect diagnosed at routine newborn examination	1
Maternal complications:	
Postpartum haemorrhage	2
Third degree tear	1

Results

Within the intended sample of white women of lower social class and educational level we had a broad spectrum of personal and demographic characteristics (table 1). Two key concepts arose from discourse analysis of the antenatal interviews: a woman's confidence in her ability to breast feed and her commitment to a particular method of feeding. This enabled women to be classified into five distinct groups according to antenatal feeding intention (see box). Antenatal and postnatal matrices of the coded themes were then created for each feeding intention group. There was no strong association between the father's antenatal views about breast feeding and the mother's feeding intention and actual behaviour. A discussion of the role of partner, family, and friends in the decision making process is available elsewhere.[20]

Feeding outcome was classified according to the definitions of Labbok and Krasovec[21] into exclusive breast feeding, high, medium, and low partial breast feeding, token breast feeding, and formula feeding. Initiation of breast feeding was defined as the baby having been put to the breast even if only once. Feeding outcome was recorded for the first 24 hours, 24-72 hours, 1 week, 2 weeks, 4 weeks, and 6 weeks.

Classification of respondents according to their confidence in their feeding intention and their commitment to particular method of feeding

Group 1—Committed breast feeders: mention perseverance and overcoming and coping with problems. Do not spontaneously bring up anticipated problems in the initial discussion about feeding intention or mention changing their mind.

Marie: "Breast feeding would be that [bonding]—that's what I want to do. It's just a lot of love and affection .... We will overcome the problems."

Group 2—Probable breast feeders: spontaneously express some doubt about their own or other women's ability to breast feed—for example, "If I am able to …", "Some women can't. …" Spontaneously mention a scenario which might make them change their decision but not in the initial discussion of feeding intention.

Carol: "Well I think I would like to breast feed it. If that is an option—I mean obviously sometimes it doesn't always work out. But if I can, I would like to do that, if it's possible."

Group 3—Possible breast feeders: less committed and spontaneously mention a scenario where they would change their decision in their initial discussion of feeding intention.

Vicky: "Yes, I would like to breast feed. Give it a go. But if it's too painful, I can't bear it, then I'll bottle feed."

Group 4—Probable formula feeders: initially say that they will formula feed or probably formula feed, but at some point in the interview mention that they might consider breast feeding or mention positive factors.

Natalie: "I did think about breast feeding at one time but my chest has been very painful. It's like started to let a little bit of milk out of the nipple and it's been very sore and painful, so I'm not quite sure now what I'll do. I have thought about it but I think I prefer bottle feeding when it comes to it. I might give it a go though, see how it goes with breast feeding."

Group 5—Committed formula feeders: do not mention possibility of changing their mind. Would not consider breast feeding.

Lisa: "I mean, I'm not going to breast feed, I know that. I definitely don't want to."

The relation between the woman's feeding intention group and feeding outcome is shown in table 2. Breast feeding was initiated by all women in the committed and probable breastfeeding groups (groups 1 and 2) but by only two of the six women in the possible breastfeeding group (group 3). One woman in the probable formula feeding group (group 4) tried a token breast feed and no women in the committed formula group (group 5) initiated breast feeding. At 6 weeks all four women in the committed breastfeeding group (group 1) were still giving some breast feeds compared with three of the six women in the probable breastfeeding group (group 2) and one of the six in the possible breastfeeding group (group 3).

Exposure to breast feeding and influence on feeding intention and behaviour

A strongly held view was that breast feeding is seldom seen or talked about. Women's history of their exposure to breast feeding was strongly associated with their antenatal commitment and confidence in their own ability to breast feed and the initiation of breast feeding. It was less strongly associated with duration and exclusivity of breast feeding. Previous exposure to breast feeding was either a positive or a negative influence on women's decision whether to breast feed, depending on the context in which it occurred. Crucial factors determining women's reactions were the nature of their relationship to the breastfeeding woman, the presence of other people and their reaction, the frequency of exposure, the perceived appropriateness of the setting, and their own level of body confidence. Many women in this study revealed negative feelings about their own bodies and low levels of body confidence. Seeing other women breast feed could either improve their body confidence or reinforce these negative feelings. When breast feeding was witnessed as part of normal everyday life by both the woman and her family and friends she was more confident in her own ability to breast feed and committed to her decision. If breast feeding had been seen only infrequently and other people present had made negative comments her reaction was less positive. This is illustrated by the quotations in the box.

How a woman performs breast feeding in front of other people was important in determining reactions of both men and women to seeing breast feeding. Performing with discretion and being aware of the sensitivities of others were approved whereas more overt breast feeding in public was off putting for most respondents. Many women and men could describe in great detail early childhood experiences of seeing breast feeding for the first time. They recalled with remarkable clarity their reactions and the reactions of others present. This suggests a deep and important learning experience.

Embarrassment about breast feeding in front of others, including close family, was commonly mentioned, though issues about sexuality were seldom spontaneously articulated by women but were mentioned by some men (see box). Non-verbal communication when these sensitive topics were discussed revealed a striking pattern across the feeding intention groups. Women committed to breast feeding (group 1) often sat forward and became increasingly assertive when talking about the dual feeding and sexual roles of breasts. Women who were less confident and committed to breast feeding (groups 2, 3, and 4) seemed to have difficulty articulating their views and their body language became more negative. Women would lean back, retreating, cover their mouth with their hands, soften their voice, or giggle nervously. Other people present at the interview would sometimes walk away. Women committed to formula feeding (group 5) seemed to distance themselves from sexual issues in the decision to breast feed and were unwilling to talk about them.

Table 2 Feeding intention and feeding outcomes at birth and at 6 weeks in women in east end of London

Feeding intention	No of women	Breast feeding initiated	Breast feeding at 6 weeks
Committed breast feeders	4	4	2 Exclusive; 1 medium partial; 1 low partial
Probable breast feeders	6	6	2 Exclusive; 1 high partial
Possible breast feeders	6	2	1 Medium partial
Probable formula feeders	2	1 (token feed)	0
Committed formula feeders	3	0	0

Women's conversation as a reflection of their level of exposure

All women in this study were aware that breast feeding is best for health. There were differences, however, in the ownership of this knowledge. There were striking differences between feeding intention groups in the language they used when they were discussing their knowledge and beliefs. The personal pronouns chosen by women reflect the level of ownership of a viewpoint,

and this was associated with their exposure to breast feeding. The following quotations illustrate this. Penny in group 2 said, "I just feel that it would be better for the baby in the long run—it's just how I would imagine that I would deal with being a mother." Penny had positive recollections of seeing her cousin breast feed and owned her beliefs about the benefits of breast feeding by using the first person singular. Vicky in group 3 said, "It protects them against catching things I suppose, like viruses—the only thing is, you don't really know how much they are getting though, do you?" Vicky remembered seeing breast feeding once on a bus as a child and being "gob smacked." She made a factual statement in the third person singular about the protective effects of breast feeding but "I suppose" suggests uncertainty of ownership. She then voiced a common concern about breast feeding by using the second person "you." This suggests collective rather than individual ownership. Hayley in group 5 said, "They say that it helps their immune system and all that. Someone did try and tell me the other day that it makes them more intelligent." Hayley reported a negative reaction to the one occasion when she witnessed breast feeding. She distanced herself from the views of others about the benefits of breast feeding by using third person pronouns "they" and "someone." She does not own these statements.

Women's stories about seeing other women breast feed

Clare (committed to breast feeding antenatally; exclusively breast feeding at 6 weeks): "We're always together anyway, so not only asking Diane [twin sister] but just seeing how she fed really helped me a lot … [Without Diane] I would probably have relied more on midwives and even though they are really, really nice, it's not as personal as it is between us. I mean we're really close. I think it would have made a lot of difference—I don't think I would have been so relaxed. I probably would have been a bit more anxious to know that she's feeding well—is she getting enough? But because of Diane I know."

Sarah (committed to breast feeding antenatally; low partial breast feeding at 6 weeks): "When she [a relative] finishes feeding, she will stay naked for maybe 2 seconds while she buttons the baby's top and puts the baby down …. It's not the breast feeding that's offensive, it's the use of the breast."

Carol (probable breast feeder antenatally; breast fed for 5 days): "My friend's mother when she had the youngest one—I would have been about 9 or 10—and I was absolutely fascinated when she suddenly just whipped up her shirt, whipped up her bra and just attached the baby and I thought, 'Oh lummy—what's happening now?' I was only young at the time but I was fascinated to see what was going on. I mean obviously it made it easier because she wasn't the slightest concerned—she had four older children anyway and they were all scampering around, so one more going 'Ooh!' didn't make a lot of difference, so—that's the only time."

Naomi (probable breast feeder antenatally; breast fed for 3 days): "When I was little, I said—'Ooh that's nasty' but as I got older, I seen a few mates have babies, they all breast feed, so I seen them breast feed. Somebody just said—it's nice to breast feed and—I don't know where I got it from really. I just thought to myself I would always try it out."

Vicky (possible breast feeder antenatally; medium partial breast feeding at 6 weeks): "While I was round the doctor's I saw a woman breast feeding. And I suppose you notice them things more but she was doing it so discretely, I don't think if a bloke was just to quickly look, you wouldn't know because she had the baby's head under her jumper. You wouldn't know. And I've fed her myself, you know, round there. You don't really see it …. I was just waiting to go in and she was hungry and I thought 'I'll feed her.' I thought I would feel embarrassed but I didn't. You know, because no one knew."

Natalie (probable formula feeder antenatally; formula feeder): "I seen a woman do it on a train once, which was a bit embarrassing. I was about 13 and I was sitting on the train and I was with me sister and she just started feeding the baby and I was sort of giggling and looking at me sister because I felt really uncomfortable about it. I couldn't look at her and that—I shouldn't be looking …. There was all men and that on the train and it felt a bit uncomfortable. If I ever did breast feed, I don't think I would do it in public. I would have to get one of them pumps they have."

Lisa (committed formula feeder antenatally; formula feeder): "I mean my cousin in Australia, I mean, she breast fed as well and she used to do it anywhere and I mean that used to embarrass me and I dunno, I think maybe that's what put me off, thinking you had to do it anywhere—like when it needs it you've got to do it."

Discussion

The finding that women of lower socioeconomic status who perceive exposure to breast feeding in a positive way may be more likely to initiate breast feeding provides a new perspective on decision making about infant feeding. With trends towards smaller family size, more women working, and increasing geographical separation of families, opportunities for exposure to breast feeding may be decreasing. Existing research looking at a possible association between exposure and the decision to breast feed has not looked in detail at the context or the frequency of exposure.[9 10 22]

Reference to the work of Hastrup was useful in developing the findings of this study into a model for decision making about infant feeding.[23] Hastrup describes two different kinds of knowledge required for performing a skill—embodied knowledge and cognitive knowledge: "Words may store cognitive knowledge but have a much lesser capacity for storing other kinds of experience, which are embodied and stored in the social-habit memory."

Possession of embodied knowledge may also explain the consistent research findings that previous feeding behaviour is the strongest predictor of future feeding behaviour and that having family and friends who breast feed is associated with deciding to breast feed.[4] The relative importance attributed to theoretical or cognitive knowledge and embodied knowledge is likely to vary between women. A hypothesis arising from this study is that for women from lower socioeconomic groups who learn skills through apprenticeship, embodied knowledge gained through exposure to breast feeding may be more influential than theoretical knowledge. In contrast, women with higher educational qualifications are more familiar with learning and making decisions on the basis of theoretical knowledge. Further research could evaluate interventions to increase women's embodied knowledge of breast feeding and the possible role of television or video as a proxy for real life exposure.

Implications for clinical practice and policy

Most clinicians ask women antenatally how they are planning to feed their baby. The emphasis is on providing factual information about the health benefits of breast feeding. Attention to women's discourse when recounting their knowledge and experience of breast feeding will help clinicians to assess a woman's confidence, commitment, and ownership of her knowledge. Women hoping to breast feed but with little exposure to breast feeding may benefit from an antenatal apprenticeship with a known breastfeeding mother.

A systematic review of mostly professional postnatal support for women wanting to breast feed concluded that extra support had a small overall benefit but not for women in lower socioeconomic groups.[24] Non-professional support for breast feeding is currently

Dual role of breasts: sexuality and feeding

Marie (committed breast feeder antenatally; medium partial breast feeding at 6 weeks): "I'm saying that my embarrassment [breast feeding in public] would be because of other people's embarrassment . . . ."

Interviewer: "What do you think, Nico [Marie's partner]?"

Nico: "Personally? Well the woman's breast is a sex—isn't it? And I don't think I would ever get used to that. I think—there will always be embarrassment. That's what I think."

Marie: "Well why? I mean you buy the tabloid rags every day—not you personally but—is that embarrassing? You don't think twice about that."

Ruth (possible breast feeder antenatally; moved away before the birth): "I've heard all these different stories, that you go off sex and—I don't want like the baby to come between us, do you know what I mean, because we are very close, we do a lot together but he has changed towards me already. He said to me: 'You're not my girlfriend, you're the girl who's having my baby'."

Caroline (probable breast feeder antenatally; breast fed for 3 weeks): "Other people find it embarrassing, especially men—they seem to be more embarrassed than the people who breast feed. We went to see my husband's friend who had had a baby recently and his wife was going to feed the baby and my husband said 'Oh, I'll go outside' you know, and she said 'No it's OK, I'm not embarrassed' but he was. So he quickly left! (laughs)."

Focus group 1

Naomi: "Dave's [Naomi's partner] told me not to do it [breast feed] in front of his mates or anything."

Sian: "Yeh, I can imagine Dave."

Suzi: "I think most men, not being funny."

Naomi: "He said to me: 'You got to go in the next room to do it'."

Suzi: "To them—in front of their mates! (giggles). In front of us—I mean we all walk around in the nude with each other and everything, it's nothing new for us."

Deana: "Yeh."

Suzi: "But if we were sitting here with her baby and Naomi, I mean, but we wouldn't bat an eyelid, but it's different with the boys. The thing is, Dave ain't looking at it as if Naomi is feeding his baby, she's parading her boobs around in front of his mates" (general agreement).

Suzi to Naomi: "It's not going to make you feel that comfortable . . . ."

Sian: "I'm sure they see things in a different light don't they."

Deana: "Sex, they probably see it as, sexy."

offered in several projects around Britain, often involving voluntary organisations like La Leche League. However, no randomised study has been performed to evaluate effectiveness and the emphasis is on postnatal support rather than antenatal apprenticeship.

Breast feeding is best considered a practical skill and a performing art. Like other bodily skills—for example, swimming—it usually needs to be learnt. Developing the confidence, commitment, and knowledge necessary to perform this new behaviour may be more effectively gained through apprenticeship to a breastfeeding mother rather than theoretically in consultations or from books.

We thank the general practitioners and midwives in Tower Hamlets and Hackney who recruited women for this study. Names used in the text are fictitious to protect confidentiality.

Contributors: PH was the principal researcher. She was involved in formulating the study goals, data gathering, analysis, and writing the paper. RP was involved in formulating the study goals, supervision of the data collection, analysis, and writing the paper. Diana Thomas transcribed the interviews, apart from the focus groups, which were transcribed by PH. PH was working as a general practitioner at St Stephen's Health Centre, Bow, London E3, when this study took place.

Funding: PH received funding from a Royal College of General Practitioners/Medical Insurance Agency Research Training Fellowship.

Competing interest: None declared.

Key messages

- Women who have seen successful breast feeding as part of their daily lives and perceive this as a positive experience are more likely to initiate breast feeding
- Embodied knowledge gained through seeing breast feeding may be more influential than theoretical knowledge about the health benefits for women of lower social class
- Listening to pregnant women talking about breast feeding could help clinicians assess the relative importance of theoretical and embodied knowledge for each woman
- Women hoping to breast feed but with little exposure to breast feeding may benefit from an antenatal apprenticeship with a breastfeeding mother
- Ideally apprenticeship would be with a breastfeeding mother from her social network to minimise the potential barriers of embarrassment and lack of confidence with strangers

1 Statement of the Standing Committee on Nutrition of the British Paediatric Association. Is breast feeding beneficial in the UK? *Arch Dis Child* 1994;71:376-80.
2 Howie PW, Forsyth JS, Ogston SA, Clark A, Florey CD. Protective effect of breast feeding against infection. *BMJ* 1990;300:11-6.
3 Wilson AC, Forsyth JS, Greene AS, Irvine L, Hau C, Howie PW. Relation of infant diet to childhood health: seven year follow up cohort of children in Dundee infant feeding study. *BMJ* 1998;316:21-5.
4 Foster K, Lader D, Cheesbrough S. *Infant feeding 1995*. London: Office for National Statistics, 1997.
5 White A, Freeth S, O'Brien M. *Infant feeding 1990*. London: Office for National Statistics, 1992.
6 Henschel D. The joint breastfeeding initiative. *Nursing Standard* 1989;4:54-5.
7 National Breastfeeding Working Group. *Breastfeeding: good practice guidance to the NHS*. London: HMSO, 1995.
8 World Health Organisation/UNICEF. *WHO/UNICEF joint statement. Protecting, promoting and supporting breast feeding: the special role of maternity services*. Geneva: World Health Organisation, 1989.
9 Hally MR, Bond J, Crawley J, Gregson B, Phillips P, Russell I. Factors influencing the feeding of first born infants. *Acta Paediatr Scand* 1984;73:33-9.
10 Bond S, Gregson BA. *Development and validation of an instrument to predict infant feeding orientation*. University of Newcastle upon Tyne: Health Care Research Unit, 1991.
11 Manstead ASR, Proffitt C, Smart JL. Predicting and understanding mothers' infant feeding intentions and behaviour: testing the theory of reasoned action. *J Personality Soc Psychol* 1983;44:657-71.
12 Wylie J, Verber I. Why women fail to breast feed: a prospective study from booking to 28 days post partum. *J Nutr Dietetics* 1994;7:115-20.
13 Maclean HM. Implications of a health promotion framework for research on breast feeding. *Health Promotion* 1989;3:355-60.
14 Patton MQ. *Qualitative evaluation and research methods*. London: Sage, 1990.
15 Hoddinott P, Pill R. Qualitative research interviewing by general practitioners. A personal view of the opportunities and pitfalls. *Fam Pract* 1997;14:307-12.
16 Miles MB, Huberman AM. *Qualitative data analysis*. London: Sage, 1994.
17 Strauss A, Corbin J. *Basics of qualitative research. Grounded theory procedures and techniques*. London: Sage, 1990.
18 Ritchie J, Spencer L. Qualitative data analysis for applied policy research. In: Bryman A, Burgess RG, eds. *Analyzing qualitative data*. London: Routledge, 1994:173-94.
19 Potter J, Wetherell M. Analyzing discourse. In: Bryman A, Burgess RG, eds. *Analyzing qualitative data*. London: Routledge, 1995:47-66.
20 Hoddinott P. Why don't some women want to breastfeed and how might we change their attitudes? [MPhil thesis.] Cardiff: University of Wales College of Medicine, 1998.
21 Labbok M, Krasovec K. Toward consistency in breastfeeding definitions. *Stud Fam Plan* 1990;21:226-30.
22 McIntosh J. Barriers to breast feeding: choice of feeding method in a sample of working class primiparae. *Midwifery* 1985;1:213-24.
23 Hastrup K. *A passage to anthropology: between experience and theory*. London: Routledge, 1995:1-217.
24 Renfrew MJ. *Postnatal support for breastfeeding mothers*. In: Cochrane pregnancy and childbirth database [revised May 1994]. *The Cochrane Library*. Cochrane Collaboration; Oxford: Update Software; 1995.

(Accepted 6 October 1998)